MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87c

CERTIFICATE OF DEATH

06053

Reg. Dist. No. 166

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Garrett
City or town Mt. Lake Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town McHenry, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Glotfelty Barney.

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife Charles Barney.
Deceased. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 27th, 1872

8. AGE: Years	Months	Days	If less than one day
74	9	3	..... hrs. ..... min.

9. Birthplace McHenry, Md. (Town, county, and state)
10. Usual occupation House wife.
11. Industry or business

FATHER
12. Name Thaddeus Glotfelty.
13. Birthplace Salisbury, Pa.

MOTHER
14. Maiden name Margaret Fratz.
15. Birthplace Accident, Md.

16. Informant James Glotfelty,
Address McHenry, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3/47 (month) (day) (year)
Cemetery or crematory Thayerville Cemetery.
Location Thayerville, Maryland.

18. Funeral director Empson & Baldwin
Address Oakland, Md.

19. July 3 1947 (Date rec'd by registrar) Julia Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947, at 12 Noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Oct 1946 to 1 July 1947 and that I last saw h[illegible] alive on 15 June 1947

Immediate cause of death	DURATION
Acute Nephritis	3 wks.
Due to Parkinsons disease	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. E. Mance M.D.
A. E. Mance, M. D. M. D. or other
Address Oakland, Md. Date signed July 2

Mr. Bolden: He is out of City
on case. Get signed as soon as possible.
Please obtain free from Healey —
Thank you J

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

930

0605[illegible]2

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Garrett
City or town Rural - Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45yrs
Hospital, Institution, or street address where death occurred:
Park Street
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Kitzmiller
(If outside city or town limits, write RURAL and give nearest town)
Street No. Park Street
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME: Delia May Boyce

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Wesley Boyce
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 13, 1870

8. AGE: Years	Months	Days	If less than one day
77	3	19	..... hrs. ..... min.

9. Birthplace: Doddridge Co.,W.Va. (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Own Home

FATHER
12. Name: Thomas True
13. Birthplace: W.Va.

MOTHER
14. Maiden name: Harriett Cottrill
15. Birthplace: W.Va.

16. Informant: Mrs. Hazel Griggs
Address: Kitzmiller, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5 1947 (month) (day) (year)
Cemetery or crematory: Mt. Zion Cemetery
Location: Mt. Zion, Garrett Co.,Md.

18. Funeral director: Otha F. Sharpless
Address: Blaine, W.Va.

19. July 4 19 47 (Date rec'd by registrar) A W Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 47 at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46, to July 2 19 47 and that I last saw h[illegible] alive on July 2 19 47

Immediate cause of death	DURATION
Acute Myocarditis	
Due to Auricular Fibrillation	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Ralph Calandella M.D. M. D. or other
Address Kitzmiller, Md Date signed July 3-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

06055

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County: Garrett

City or town: Mt. Lake Pa rk,

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, Institution, or street address where death occurred: Kiser Nursing Home

How long in hospital or Institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alexander M. Click

3.(b) Social Security Number: not known

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Click

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): April 2, 1875

8. AGE:

Years	Months	Days	If less than one day
72	3	13	....hrs. ....min.

9. Birthplace: Mount Jackson, Va. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Jacob Click

FATHER — 13. Birthplace: Rockingham Co., Va.

MOTHER — 14. Maiden name: Elizabeth Mumaw

MOTHER — 15. Birthplace: Shenandoah Co., Va.

16. Informant: Alice Click

Address: Mount Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17, 1947 (month) (day) (year)

Cemetery or crematory: Oakland, Cemetery

Location: Oakland, Maryland.

18. Funeral director: Herbert C. Leighton

Address: Oakland, Maryland.

19. July 17 19 47 Julia A. Rowan

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947 at 5:00A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 6-19-47 19.. to 7-14-47 19..

and that I last saw h... im alive on 7-13-47 19..

Immediate cause of death	DURATION
Heart attack	
Due to: Miners Asthma Chronic Bronchitis	
Heart Lesio n	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ....Injured at work?

23. SIGNATURE: Edward H. Hamilton M. D.

Address: Oakland, Md ....Date signed 7-16-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Miss Jones- I am unable to obtain the family history - any I have tried to locate the nearest relative

Will you try and get the family history

Pat

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06056

Reg. Dist. No. 162

1. PLACE OF DEATH:
County: Garett
City or town: Accident
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Rural Near Accident
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Henrietta Katharine Deal

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Earl Deal
6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): April I2-I9I4

8. AGE:	Years	Months	Days	If less than one day
	33	3	I6	hrs. min.

9. Birthplace: Rural Near Accident Md
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business

FATHER
12. Name: Fred Bowser
13. Birthplace: R.D Accident Md

MOTHER
14. Maiden name: Lydia Fresh
15. Birthplace: R.D. Accident Md

16. Informant: Fred Bowser
Address: R.D. Accident Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3I-I947 (month) (day) (year)
Cemetery or crematory: Zion Luthern
Location: Accident Md
18. Funeral director: Wm Winterberg
Address: Grantsville Md

19. July 30 1947 (Date rec'd by registrar) Ethel B Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 1947 at 11:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Summer 26 to 28th 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fractured Skull	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 7/28/47
Where did injury occur? Accident (City or town) Garrett (County) Md (State)
Injured at home, farm, industry, public place (where?) U.S. Route 219
Means of injury Fell out yautomobile Injured at work? No Dead, Ford.

23. SIGNATURE: E. L. Baumgartner M.D. Summer Forest
M. D. or other
Address: Oakland Md Date signed 7/28/47

VS, A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

C6066 182
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town Fallston R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Fallston R.F.D. #1
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ethel Batson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife John S. Batson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1889

8. AGE: Years	Months	Days	If less than one day
57	11	5	..... hrs. ..... min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name William W. Buchanan

FATHER 13. Birthplace Penna.

MOTHER 14. Maiden name Lottie Bond

MOTHER 15. Birthplace Benson, Maryland

16. Informant Mr. John S. Batson

Address Fallston, R. F. D. #1, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7 (month) 29 (day) 47 (year)

Cemetery or crematory Fawn Grove Cemetery Fawn Grove Pa

Location Fallston, Md Fawn Grove Pa

18. Funeral director Elmer E. Bullock

Address 556 Lewis St. Havre de Grace, Md

19. 7/27 1947 (Date rec'd by registrar) Priscilla Fonwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to July 25 1947 and that I last saw her alive on July 25 1947

Immediate cause of death Coronary Thrombosis — DURATION: Sudden death

Due to

Due to

Other conditions Essential hypertension — DURATION: 6 yrs.
Chr. Myocardial Disease — DURATION: 3 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

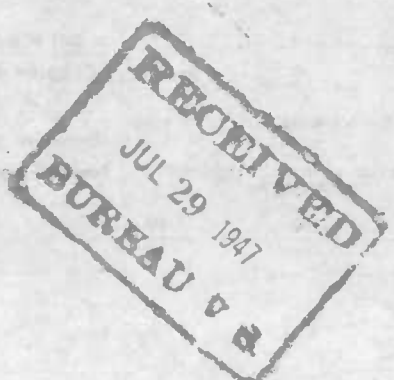
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. Heedom
M. D. or other

Address Forest Hill Md Date signed 7/27/47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JUL 29 1947
BUREAU V &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170c

CERTIFICATE OF DEATH

C5486

Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
City or town Darlington Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Darlington Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) No
2.(a) If veteran, name war

3.(a) FULL NAME JESSE MORRIS CARR

3.(b) Social Security Number No

4. Sex	5. Color or race	6. (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6.(b) Name of husband or wife Sally C Carr
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 5, 1876

8. AGE: Years 70 Months 7 Days 10 If less than one day hrs. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business Housework

FATHER
12. Name Marion Carr
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden name Margaret Morris
15. Birthplace Harford Co. Md.

16. Informant Mrs James Murphy
Address Darlington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 1947 (month) (day) (year)
Cemetery or crematory Emory Cem.
Location Harford Co., Md.

18. Funeral director H. S. Bailey
Address Darlington, Md.

19. July 16 1947 (Date rec'd by registrar) M. V. Kirk Registrar

MEDICAL CERTIFICATION gpmx

20. DATE OF DEATH July 15 1947, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death Fracture of Skull — DURATION

Due to

Due to

Other conditions Multiple Lacerations & Contusions Face, nose, hands, legs
(Include pregnancy within 3 months of death)

Major findings of operation None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7/15/47
Where did injury occur? Near Dublin Harford Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route #1
Means of injury Struck by Car Injured at work? no.

23. SIGNATURE J. H. Lamm M.D.
Deputy Medical Examiner
Address Aberdeen, Md. M. D. or other Date signed 7/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93a

CERTIFICATE OF DEATH

66067

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 87 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 227 S. Union Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Harry Allen Carroll

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 9- 1809

8. AGE: Years 87 | Months 9 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace Havre de Grace Md. (Town, county and state)

10. Usual occupation Retired Postmaster

11. Industry or business —

FATHER
12. Name Thomas Carroll
13. Birthplace New Jersey

MOTHER
14. Maiden name Mary Allen
15. Birthplace Pa.

16. Informant Charlotte Carroll
Address 227 S. Union Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/23/47 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace

18. Funeral director Pennington & Son
Address Havre de Grace, Md.

19. July 22 1947 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to July 20 1947
and that I last saw h... alive on July 20 1947

Immediate cause of death — DURATION
Arteriosclerosis
Hypertension
Due to Acute Myocarditis
Due to —
Other conditions Cardiac Failure
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Charles J. Foley M.D. M. D. or other
Address Havre de Grace Date signed 7/22/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

06068

CERTIFICATE OF DEATH

Reg. Diat. No. 183

1. PLACE OF DEATH:

County Harford

City or town Upper X Roads

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Harford

City or town Upper X Roads

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles Edward Coe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Virginia Coe

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) March 5, 1869

8. AGE: Years 78 | Months 4 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace Greenwood Balto co md

(Town, county, and state)

10. Usual occupation Painter

11. Industry or business general house painting

FATHER 12. Name Lambert Thomas Coe

FATHER 13. Birthplace Balto. co md.

MOTHER 14. Maiden name Emma V. Monroe

MOTHER 15. Birthplace Balto co md

16. Informant Virginia Coe

Address Fallston RD Harford Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12, 1947 (month) (day) (year)

Cemetery or crematory Providence

Location Upper X Roads Harford Co Md

16. Funeral director Martin L. Kurtz

Address Jarrettsville, Md

19 July 12 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 47 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. T. Ramsey M. D. Deputy Medical Examiner

Address Aberdeen, Md. Date signed 7/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06069

Reg. Diat. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Jarrettsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Robert William Daughton

3.(b) Social Security Number 217-20-0955

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bertha W Comrie
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Nov 21 1894

8. AGE: Years	Months	Days	If less than one day
62	8	2	hrs. min.

9. Birthplace: Jarrettsville
(Town, county, and state)
10. Usual occupation: Tool Clerk
11. Industry or business: Glen L Martin Co
FATHER 12. Name: Benj Franklin Daughton
13. Birthplace: V
MOTHER 14. Maiden name: Elizabeth Rickour
15. Birthplace: Balto - md
16. Informant: Bertha W Daughton
Address: Jarrettsville - Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25-47 (month) (day) (year)
Cemetery or crematory: Jarrettsville
Location: Jarrettsville Md.
18. Funeral director: Martin E Kurtz
Address: Jarrettsville Md.
19. July 25 1947 (Date rec'd by registrar) Homer P Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 23rd 1947 at 4 20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 27 1946, to July 23 1947 and that I last saw him alive on July 22 1947

Immediate cause of death	DURATION
Epithelioma of Tongue	1yr.
Due to	
Due to	
Other conditions	

(Include pregnancy, within 3 months of death)

Major findings of operations: Biopsy: Epithelioma of Tongue
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill, Md Date signed 7/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06070

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: HARFORD
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN DEWBERRY

3.(b) Social Security Number: 217-16-3403

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of ~~husband or~~ wife: Irene Sanders
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years: 62 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Day Labor

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: John Lee Dewberry
Address: 508 N. Norris St Baltimore Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 23-1947 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Near Aberdeen Md

18. Funeral director: Henry Tarring Sons
Address: Aberdeen Md.

19. July 23 1947 (Date rec'd by registrar) Nellie F Kelley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1947, at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Lammey M.D.
County Medical Examiner or other
Address: Aberdeen, Md. Date signed: 7-21-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06071

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Harford
City or town: Bel Air Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Rural - Bel air
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Almshouse
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Samuel Dutton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Widow

6.(b) Name of husband or wife: Susan Brown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): NOV 14-1874

8. AGE: Years	Months	Days	If less than one day
72			..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: UNKNOWN
13. Birthplace: UNKNOWN

MOTHER
14. Maiden name: UNKNOWN
15. Birthplace: UNKNOWN

16. Informant: Clark Fitzpatrick
Address: Bel Air, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21/47 (month) (day) (year)
Cemetery or crematory: County Home
Location: Near Bel Air, Md

18. Funeral director: Dean & Foster
Address: Bel Air Md

19. 7/19 (Date rec'd by registrar) 1947 Priscilla Fawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1947 at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1947 to July 18 1947 and that I last saw him alive on July 16 1947

Immediate cause of death	DURATION
Coronary Thrombosis	30 min.
Due to	
Due to	
Other conditions: Cerebral Hemorrhage with hemiplegia	7 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

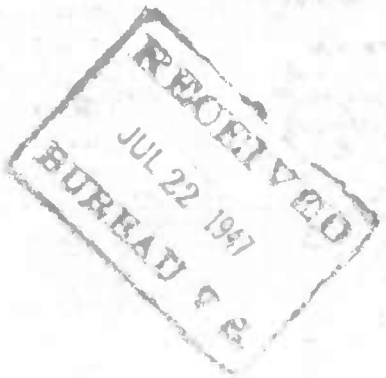
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed: 7/18/47

MARGIN RESERVED FOR BINDING (I)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M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BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

06072

CERTIFICATE OF DEATH

Reg. Diat. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: 12 Victory St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 414 Seward St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Thomas Joseph Flatley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Virginia F. Haire
6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): March 26, 1900

8. AGE: Years: 47 | Months: 3 | Days: | If less than one day: hrs. min.

9. Birthplace: Chicago Ill. (Town, county, and state)

10. Usual occupation: Federal Housing Mgr.

11. Industry or business:

FATHER
12. Name: John F. Flatley
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Virginia F. Flatley
Address: 12 Victory St. Aberdeen

17. Burial, cremation, or removal. Which? Burial
Date thereof: July 26 1947 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington, D.C.

18. Funeral director: Henry J. Bring & Sons
Address: Aberdeen, Md.

19. Filed: July 24 1947 (Date rec'd by registrar) Nellie L. Giles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1947, at 11:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1947 to July 27 1947 and that I last saw h[er] alive on July 27 1947

	DURATION
Immediate cause of death: acute congestive Heart failure	24 hrs
Due to: Coronary Thrombosis	6 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H K Dorsey M.D.
M. D. or other
Address: Aberdeen Md. Date signed: July 23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Q6073

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Federal Hill (Rocks R.D.) Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Federal Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: CLINTON FLICHMAN

3.(b) Social Security Number: —

4. Sex: M.
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Carrie Paxton Flichman
6.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): May 13, 1884
8. AGE: Years: 63 Months: 2 Days: 14 If less than one day: hrs. min.
9. Birthplace: Carroll Co. Md (Town, county, and state)
10. Usual occupation: General Laborer
11. Industry or business:
FATHER 12. Name: Jacob Flichman
13. Birthplace: not Known
MOTHER 14. Maiden name: Susanna Deets
15. Birthplace: not known
16. Informant: Carrie C. Flichman
Address: Rocks, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29 1947 (month) (day) (year)
Cemetery or crematory: Jarrettsville
Location: Jarrettsville Md
18. Funeral director: Martin L. Kurtz
Address: Jarrettsville Md.
July 29 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1947, at 6:45A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946, to July 27 1947
and that I last saw h.i.m. alive on July 27 1947
Immediate cause of death: CONGESTIVE HEART FAILURE — DURATION: 2 DAYS
Due to: PULMONARY FIBROSIS, PROB. TUBERCULOUS — 5 YEARS
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert A. Barthel M.D.
M. D. or other
Address: FOREST HILL, MD. Date signed: 7/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06074

93d

CERTIFICATE OF DEATH

Reg. Diat. No. 182

1. PLACE OF DEATH:

County: Harford

City or town: Fallston md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Fallston

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Louise Givens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Walter T. Givens

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): 1870

8. AGE: Years: 75 Months: 8 Days: 13 If less than one day: hrs. min.

9. Birthplace: Huffman Craig Co Va (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

MOTHER FATHER

12. Name: John L. Kinsley

13. Birthplace: Huffman Va

14. Maiden name: Armintia Rock

15. Birthplace: Huffman - Va

16. Informant: Walter T. Givens

Address: Fallston - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 7 1947 (month) (day) (year)

Cemetery or crematory: Mountain Christian Cemetery

Location: Joppa. Md

18. Funeral director: W. H. Archer

Address: Benson - Md

19. 7/7 1947 (Date rec'd by registrar) Priscilla Fawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 5 1947 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1947 to July 5 1947 and that I last saw h alive on July 3 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr.
Due to: Hypertensive Cardio Vascular Disease	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Alfred T. Hudson M.D. M. D. or other

Address: Fork, Md. Date signed: 7/5/1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

06075

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Belair

(If outside city or town limits, write RURAL and give nearest town)

Street No. 133 Archer St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C.	Marr.

6.(b) Name of husband or wife: Josiah Lee Hall.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10-8-1871

8. AGE: Years	Months	Days	If less than one day
75	9	12	..... hrs. ..... min.

9. Birthplace: Harford County Maryland (Town, county, and state)

10. Usual occupation: Houese wife

11. Industry or business

FATHER

12. Name: Josiah Lee

13. Birthplace: Harford County Maryland

MOTHER

14. Maiden name: No Record

15. Birthplace: Harford County Md

16. Informant: Mrs. Josiah Lee Hall

Address: 133 Archer St. Bel-air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-23-47 (month) (day) (year)

Cemetery or crematory: Ashburning Cemetery

Location: Churchville, Md.

18. Funeral director: Edward E. Bullock

Address: 556 Lewis St. Havre de Grace, Md

19. JULY 23 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20th 1947 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19th 1947 to July 20th 1947

and that I last saw h... or alive on July 20th 1947

Immediate cause of death: Gastric hemorrhage (recurrent) — DURATION

Due to: Possibly, an ulcer or malignant tumor of stomach

Due to:

Other conditions: Hypertensive cardiovascular disease

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John F. Noguera MD (M. D. or other)

Address: Harford Mem. Hosp. Date signed 7/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

06076 182

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Rural - Whiteford, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 32 years

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural - Whiteford

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Prospect

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Oliver Thomas Henry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife: Annie Elizabeth Henry

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): December 1, 1881

8. AGE:

Years	Months	Days	If less than one day
65	7	6	— hrs. — min.

9. Birthplace: Whiteford, Harford, Md. (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: —

FATHER

12. Name: Thomas Henry

13. Birthplace: Whiteford, Md.

MOTHER

14. Maiden name: Mary Jane Barber

15. Birthplace: Allentown, Pa.

16. Informant: Arthur Samuel Henry

Address: Chattanooga, Tenn.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10-1947 (month) (day) (year)

Cemetery or crematory: DARLINGTON CEM.

Location: DARLINGTON, Md.

18. Funeral director: HUBERT P HARKINS

Address: DELTA, Pa.

19. July 9 1947 (Date rec'd by registrar) W. H. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1947, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1946 to July 1947 and that I last saw him alive on July 7, 1947

Immediate cause of death	DURATION
Pulmonary edema	2 days.
Due to: Cardiac failure	6 mo.
Due to: Arteriosclerotic heart disease.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None.

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles A. Hoff MD. M. D. or other

Address: Street, Md. Date signed: 7-7-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

06077

Reg. Dist. No. 183

1. PLACE OF DEATH:
County: Harford
City or town: Taylor, Mountain Rd.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Taylor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Matthew Lawrence Holden

3.(b) Social Security Number: 214-22-9457

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Marion Filyaw
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Feb 15 1885

8. AGE: Years: 62 Months: 5 Days: 29 If less than one day: hrs. min.

9. Birthplace: Wexford Ireland
(Town, county, and state)

10. Usual occupation: Stable manager

11. Industry or business: Farm & Elkridge Hunt

FATHER
12. Name: Matthew Holden
13. Birthplace: Ireland

MOTHER
14. Maiden name: Ann Kavanaugh
15. Birthplace: Ireland

16. Informant: Matt Holden
Address: Mountain Rd Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 17-47 (month) (day) (year)
Cemetery or crematory: St Johns
Location: Long Green Bald Eagle Md

18. Funeral director: Martin Grant
Address: Jarrettsville Md

19. July 17 1947 (Date rec'd by registrar) Thomas R Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1947 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Intracranial Hemorrhage	
Due to: Fracture of Skull	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

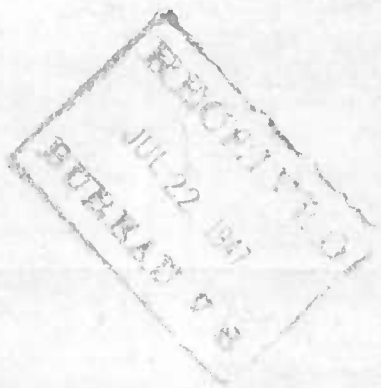
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 7/14/47
Where did injury occur? Taylor (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?) Route # 146
Means of injury: Struck By Auto Injured at work? No

23. SIGNATURE: J. H. Lamar M.D.
Dep. Md. Examiner M.D. or other
Address: Aberdeen, Md. Date signed: 7/14/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
JUL 22 1987
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

06078

Reg. Dist. No. 181

1. PLACE OF DEATH:

County: Harford

City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural - Perryman
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Forest Green
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: W Carl Holloway

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Ethel V. Hinchman

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): April 2, 1878

8. AGE:

Years	Months	Days	If less than one day
69	Ot 2		..... hrs. ..... min.

9. Birthplace: Perryman, Harford Co. Md.
(Town, county, and state)

10. Usual occupation: Deputy Collector of

11. Industry or business: Internal Revenue

FATHER
12. Name: Charles E. Holloway
13. Birthplace: Perryman Md.

MOTHER
14. Maiden name: Catherine Ballard
15. Birthplace: Perryman Md.

16. Informant: Mrs. W Carl Holloway
Address: Perryman Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: July 20, 1947
(month) (day) (year)

Cemetery ~~or crematory~~: Spesutia

Location: Perryman

18. Funeral director: Henry Parrish & Sons

Address: Aberdeen Md.

19. July 19 1947 (Date rec'd by registrar) Nellie L. Tiley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18 1947 at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1947 to July 18 1947 and that I last saw h... alive on July 17 1947

Immediate cause of death	DURATION
Coronary Heart Disease	
Due to: Arterio sclerotic hypertensive cardio vascular disease	3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: GB Jastram MD
M. D. or other

Address: Aberdeen Md Date signed: 7/18/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

06079

CERTIFICATE OF DEATH

Reg. Dist. No. 182

M

1. PLACE OF DEATH:

County: Harford

City or town: Bel Air Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: 120 Aliceanna St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 120 Aliceanna

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: George Willis James

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband~~x~~ wife: Ella Duff

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 30th, 1878

8. AGE:

Years	Months	Days	If less than one day
69	1		..... hrs. ..... min.

9. Birthplace: Harford Co. Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Samuel James

FATHER — 13. Birthplace: Harford Co

MOTHER — 14. Maiden name: Martha M. Walton

MOTHER — 15. Birthplace: Harford Co. Md

16. Informant: Mrs. Bertha J. Pastorfy

Address: 120 Aliceanna St. Bel Air Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1947 (month) (day) (year)

Cemetery or crematory: Mountian

Location: Wilna Harford Co.

18. Funeral director: Henry Fanning Sons

Address: Aberdeen Md.

19. 7/30 1947 (Date rec'd by registrar) Priscilla Fowoon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29 19 47, at 9:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chronic Congestive Heart failure	
Chronic Nephritis	
Due to arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Ramsey M. D. Deputy Medical Examiner (Coroner or other)

Address: Aberdeen, Md Date signed: 7/29/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468

06080

CERTIFICATE OF DEATH

Reg. Dist. No. 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Harford
City or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Magnolia
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lena Jeffers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James Jeffers
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1883

8. AGE: Years	Months	Days	If less than one day
64	3	27	..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
12. FATHER Name Frederick Gutermuth
13. FATHER Birthplace Germany
14. MOTHER Maiden name Elizabeth Berkes
15. MOTHER Birthplace Germany
16. Informant Eva Hayes
Address Magnolia Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8, 1947 (month) (day) (year)
Cemetery or crematory Cokesbury
Locafion Abingdon Maryland
18. Funeral director Howard E. McConnaughey
Address Abingdon Md
19. July 8 1947 (Date rec'd by registrar) Mary M. Monksdale Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to July 5 1947 and that I last saw h[illegible] alive on July 5 1947

	DURATION
Immediate cause of death Carcinoma pancreas	6 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer M.D.
M. D. or other
Address Bel Air, Md. Date signed 7/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1608

CERTIFICATE OF DEATH

06081

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Aberdeen (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 Hours, 4 Minutes

Hospital, institution, or street address where death occurred: Station Hospital, APG, Md.

How long in hospital or institution? 17 hrs, 4 min.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1533 East Pratt (If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Johnson, Baby Boy

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	S

6.(b) Name of husband or wife: None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 1, 1947

8. AGE: Years | Months | Days | If less than one day: 17 hrs. 4 min.

9. Birthplace: Aberdeen, Harford, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Wm. Cecil Johnson
13. Birthplace: Maysville, Ky.

MOTHER
14. Maiden name: Amanda Ellen Barnes
15. Birthplace: Holt Co. Missouri

16. Informant: Mrs Amanda Johnson
Address: 1532 E. Pratt, Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/6/47 (month) (day) (year)

Cemetery or crematory: Fairmount

Location: Baltimore Md

18. Funeral director: Wilson & Son

Address: 1214 E Fort Ave

19. 7/3 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 July 19 47, at 8:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 19 47, to 2 July 19 47

and that I last saw him alive on 2 July 19 47

	DURATION
Immediate cause of death: Intra cranial Damage	
Due to: Face Presentation	
Due to:	
Other conditions: Edema and Cyanosis of Face. Gangrene of lips	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George Knauer Jr Capt MC. M. D. or other

Address: STA. HOSP. APG. Md. Date signed: 3 July 47

Evidence for the change made is shown on G 112 9/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 06082 5-

1. PLACE OF DEATH: 112 AUG 28 1947

County Harford

City or town Havre de Grace R. F. D. 1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. F. D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Estelle V. Johnson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife William Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 5, 1899

8. AGE:

Years	Months	Days	If less than one day
47	10	13	— hrs. — min.

9. Birthplace Aberdeen, Harford, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Geo. Stansbury

13. Birthplace Harford County, Md

MOTHER

14. Maiden name Miss Hattie Christy

15. Birthplace Aberdeen, Maryland

16. Informant Mrs Ossie Du Kaiser

Address 381 Wilson St. Havre de Grace

17. Burial Date thereof 7-22-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Aberdeen, Maryland

18. Funeral director Elmer E. Bullock

Address 556 Lewis St. Havre de Grace, Md

19. July 22 1947 A. L. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to July 18 1947

and that I last saw her alive on May 12 1947

Immediate cause of death Myocardial infarction — DURATION (Terminal)

Due to Coronary Arteriosclerosis — 2 years

Due to

Other conditions Chronic Bronchitis — 5 years
Obesity — 10 years
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Peter W. Rodman M. D.
M. D. or other

Address W. Bel Air Ave., Aberdeen, Md. Date signed 7/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170c

06083

CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ days

Hospital, institution, or street address where death occurred: Harford Memorial Hospital

How long in hospital or institution? 2½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Harford

City or town: Perryman
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: World War #2

3.(a) FULL NAME: JAMES A JOHNSON JR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 9, 1925

8. AGE: Years	Months	Days	If less than one day
22	2		hrs. min.

9. Birthplace: Perryman, Harford Co., Md.
(Town, county, and state)

10. Usual occupation: Taxi Cab driver

11. Industry or business:

FATHER — 12. Name: James A. Johnson, Sr.

FATHER — 13. Birthplace: Perryman, Md.

MOTHER — 14. Maiden name: Mayfield Peace

MOTHER — 15. Birthplace: Havre de Grace, Md.

16. Informant: James A. Johnson, Sr.

Address: Perryman Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5 1947 (month) (day) (year)

Cemetery or crematory: Union M. E.

Location: Near Aberdeen

18. Funeral director: Henry Tarring & Sons

Address: Aberdeen Md.

19. July 3 1947 A. L. Lewis Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1 1947, at 11:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1947, to July 1 1947

and that I last saw h... alive on July 1, 1947

Immediate cause of death: Cerebral Concussion

Probable Intracranial Hemorrhage

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of June 28, 1947

Where did injury occur? near Aberdeen (City or town) Harford (County) Md. (State)

Injured at home, farm, industry, public place (where?): auto = 40

Means of injury: auto accident Injured at work? Yes

23. SIGNATURE: J. H. Lammey M. D.

Deputy Med. Examiner M. D. or other

Address: Aberdeen, Md. Date signed 7/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170c

06084

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2.
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 5 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. 200 N. Union Ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME JOHN Wesley KEITHLY Jr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1914

8. AGE: Years	Months	Days	If less than one day
32	7	15	— hrs. — min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual occupation Taxi Driver
11. Industry or business
FATHER 12. Name John W. Keithley Sr.
13. Birthplace Md.
MOTHER 14. Maiden name Carrie Coale
15. Birthplace Md.
16. Informant Mrs. Hazel L. Mitchell
Address 742 Ontario St. Havre de Grace Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9, 1947 (month) (day) (year)
Cemetery or crematory Smith Chapel
Location Harford Co. Md.
18. Funeral director R. Madison Mitchell
Address Havre de Grace, Md.
19. July 8 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947 at 9 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Concussion	
Probable Intracranial	
Due to hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7/6/47
Where did injury occur? near Principio Cecil Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route # 40
Means of injury Collision with auto Injured at work? no

23. SIGNATURE J. A. Ramsey M. D.
Deputy medical Examiner
(M. D. or other)
Address Aberdeen, Md. Date signed 7/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06085

CERTIFICATE OF DEATH

Reg. Dist. No. 18 S-

1. PLACE OF DEATH

County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs.

Hospital, institution, or street address where death occurred: St. Francis Villa

How long in hospital or institution? 7 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. Market & Commerce

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Sister Mary Ladislaus (Marie Veronica Koob

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 16 - 1891

8. AGE: Years: 55 Months: 11 Days: 22 If less than one day: hrs. min.

9. Birthplace: Philadelphia Pa. (Town, county, and state)

10. Usual occupation: Teacher

11. Industry or business:

FATHER — 12. Name: Jacob H. Koob

13. Birthplace: Phila. Pa.

MOTHER — 14. Maiden name: Mrs. Elizabeth Tigler

15. Birthplace: Phila. Pa.

16. Informant: Hosp. Records

Address: Market & Commerce

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/11/47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore Md.

18. Funeral director: Pennington & Son

Address: Havre de Grace Md.

19. July 10 1947 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1947, at 10:50 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to July 9 1947, and that I last saw h[illegible] alive on July 9 1947.

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	
Due to:	
Due to: Cachexia	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Havre de Grace Date signed: July 10 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48B

06086

CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 8 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. 130 Weber

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Lenora May Laye

3.(b) Social Security Number —

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Randolph T. Laye (dec)

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 3- 1888

8. AGE: Years	Months	Days	If less than one day
58	9	22	...hrs. ...min.

9. Birthplace Havre de Grace (Town, county, and state)

10. Usual occupation Home wife

11. Industry or business —

FATHER 12. Name Frank Fadley

13. Birthplace Havre de Grad

MOTHER 14. Maiden name Katherine Stone

15. Birthplace Cecil Co. Md.

16. Informant Sadie M. Donnah

Address 130 Weber St. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/28/47 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace

18. Funeral director Pennington & Son

Address Havre de Grace, Md.

19. July 26 1947 (Date rec'd by registrar) H. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947 at 12 N M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 47, to July 25 1947

and that I last saw him alive on July 23 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions Carcinoma	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles F. Foley M.D. or other

Address Havre de Grace Md. Date signed 7/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

06087

CERTIFICATE OF DEATH

Reg. Diat. No. 185

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. /

(If rural, give LOCATION)

2.(a) If veteran, name war /

3.(a) FULL NAME PAUL F LYNCH

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Margaret Lynch

6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) June 26, 1892

8. AGE: Years 55 Months 5 Days 13 If less than one day ..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Michael McGrath

13. Birthplace Ireland.

MOTHER 14. Maiden name /

15. Birthplace Ireland.

16. Informant Mrs Paul Lynch

Address Fallston Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 7-47 (month) (day) (year)

Cemetery or crematory St. John's.

Location near Creswell.

18. Funeral director Chas E Cross.

Address Benson Md

19 July 8 19 47 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death Cerebral Concussion

Due to Intracranial Hemorrhage

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/7/47

Where did injury occur? Near Fallston (Harford Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) along Route #1

Means of injury Fell down Bank Injured at work? No

23. SIGNATURE J. H. Lamon M. D.

Address Aberdeen, Md Date signed 7/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06088

Reg. Dist. No. 182

M

1. PLACE OF DEATH:
County Harford
City or town Madonna Land
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County HARFORD
City or town EDGEWOOD MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ERNEST B Maddox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mrs. Hazel Maddox
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 9 1884

8. AGE: Years	Months	Days	If less than one day
63			..... hrs. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business

FATHER
12. Name John H MADDOX
13. Birthplace VIRGINIA

MOTHER
14. Maiden name MARGARET MADDOX
15. Birthplace ELKINS - VA.

16. Informant Mrs. Hazel Maddox
Address Fallston Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/29/47 (month) (day) (year)
Cemetery or crematory Friendship M E
Location Fallston Md
18. Funeral director Chas E Gross
Address Benson Md

19. 7/28/47 (Date rec'd by registrar) Priscilla Forword Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947 at 11.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gerald C Palmer M.D.
Acting Deputy Medical Examiner Harford County
Address Bel Air, Md. Date signed 7/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

06089

Reg. Dist. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: York

City or town: Hanoverville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: York

City or town: Hanoverville Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ross E. McAllister

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Mrs. E. McAllister

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): July 4, 1885

8. AGE: Years: 62 | Months: 0 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Hopewell Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home Keeping

FATHER

12. Name: Joshua Bonstone

13. Birthplace: Hopewell Co. Md.

MOTHER

14. Maiden name: Mary Allen

15. Birthplace: Hopewell Co. Md.

16. Informant: Mrs. E. McAllister

Address: Farm Grove Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 21, 1947 (month) (day) (year)

Cemetery or crematory: Farm Grove

Location: Farm Grove Pa.

18. Funeral director: J. Howard Hess

Address: Farm Grove Pa.

19. July 21 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1947, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1947, to July 17 1947

and that I last saw h[illegible] alive on July 17 1947

Immediate cause of death	DURATION
Central Hemorrhage	6 days
Due to Arterio sclerosis	
Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

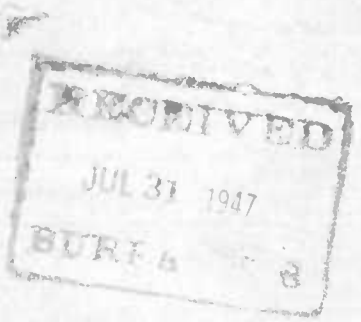
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Edward H. Hyson M. D. or other

Address: Farm Grove, Pa. Date signed: 7/15/47


RECEIVED
JUL 31 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

06090

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL and give nearest town)

Street No. Elizabeth St.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Barney L. McDonigal

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marion R. McDonigal

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 27 - 1867

8. AGE: Years	Months	Days	If less than one day
79	8	13	...hrs. ...min.

9. Birthplace Havre de Grace, Md. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business —

FATHER — 12. Name Barney L. McDonigal Sr.

13. Birthplace Ireland

MOTHER — 14. Maiden name Margaret Hubert

15. Birthplace Maryland

16. Informant Marion R. McDonigal (wife)

Address Elizabeth St. Havre de Grace

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/22/47 (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace, Md.

18. Funeral director Pennington & Son

Address Havre de Grace

19. July 22 19 47 (Date rec'd by registrar) A. L. Lewis M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 47 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1936 to July 20 1947 and that I last saw h... alive on July 20 19...

Immediate cause of death	DURATION
Chronic Valvular Disease of Heart	
Due to Chronic Myocarditis	
Due to	
Other conditions Cardiac Failure	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Foley M.D.

M. D. or other

Address Havre de Grace Md. Date Signed 7/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

06091

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Harford
City or town Edgewood Housing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Edgewood Housing Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Margaret Jane Mitman

3. (b) Social Security Number —

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Fred S. Mitman
6. (c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): Apr. 28, 1885

8. AGE: Years 62 | Months 2 | Days 10 | If less than one day: hrs. min.

9. Birthplace: Penn (Town, county, and state)
10. Usual occupation: Home Duties
11. Industry or business:

FATHER
12. Name: Henry A. Ickes
13. Birthplace: Penn.

MOTHER
14. Maiden name: Margaret Jane Rosser
15. Birthplace: Pa.

16. Informant: Mr. Frederick S. Mitman
Address: Edgewood Housing Edgewood Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11 1947 (month) (day) (year)
Cemetery or crematory: Mazepha Evangelical Cem.
Location: Union C. Pa.

18. Funeral director: P. Madison Mitchell
Address: Havre de Grace, Md.

19. July 9 1947 Nellie H. Riley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 1947, to July 8 1947 and that I last saw her alive on July 8 1947

	DURATION
Immediate cause of death: L/F ventricular failure with sudden asphyxia	15 min.
Due to: left ventricular paroxysmal tachycardia	15 min.
Due to: Acute coronary occlusion	4 days
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State) no.
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Aubrey V. Gould Jr. M.D. M. D. or other
Address 226 So. Washington St. Havre de Grace, Md. Date signed 7/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 w

06092

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Harford

City or town: Forest Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Forest Hill Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret A. Nagle

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Samuel J. Nagle

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 8 1863

8. AGE: Years 83 Months 10 Days 7 If less than one day hrs. min.

9. Birthplace: Harford Co Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeping

FATHER 12. Name: Daniel Bond

FATHER 13. Birthplace: Harford Co Md

MOTHER 14. Maiden name: Margaret Ann Bond

MOTHER 15. Birthplace: Harford Co Md

16. Informant: Mrs. M. Pyle

Address: York Pa

17. Burial, cremation, or removal. Which? Burial Date thereof July 28 1947 (month) (day) (year)

Cemetery or crematory: Bethel Cemetery

Location: Forest Hill Md

18. Funeral director: Howard Pyle

Address: Forest Grove Pa

19. 7/28 1947 Priscilla Fawcett Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1947, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to July 26 1947 and that I last saw h.r alive on July 26 1947

Immediate cause of death	DURATION
Carcinoma of Colon	7
Due to	
Due to	
Other conditions: Chr. Myocardial Disease Essential Hypertension (Include pregnancy within 3 months of death)	6 yr 4 yrs.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill Md Date signed: 7/26/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

06093

Reg. Diat. No. 183

1. PLACE OF DEATH:
County Harford
City or town White Hall R.D. (Shawsville)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town White Hall Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Streett Nelson

3.(b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife Thomas R. Nelson
6.(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) -- -- 1866

8. AGE: Years	Months	Days	If less than one day
81	-	-	...hrs. ...min.

9. Birthplace Jarrettsville Harford Co. Md. (Town, county, and state)
10. Usual occupation House wife
11. Industry or business
FATHER 12. Name John Thomas Street
13. Birthplace Rocks Md
MOTHER 14. Maiden name Mary M. Boy
15. Birthplace Cooptown Harford Co. Md.
16. Informant Thomas R. Nelson
Address White Hall, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18 - 47 (month) (day) (year)
Cemetery or crematory Bethel
Location Madonna Harford Co., Md.
18. Funeral director Martin G. Kurtz
Address Jarrettsville, Md.
19. July 18, 1947 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947 at 6:30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 17 1947, to July 16, 1947 and that I last saw her alive on July 15, 1947

Immediate cause of death	DURATION
Shock from a fractured left hip from a fall.	
Due to	
Due to Chr. Pul. Tuberculosis & general asthemia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Acc. Date of about 7/12/47
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Kitchen floor
Means of injury fall Injured at work? (7/12/47 abt)

23. SIGNATURE Norman H. Lemmell M.D. M. D. or other
Address Stewartstown, Pa. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

CERTIFICATE OF DEATH

06094

Reg. Diat. No. 191

1. PLACE OF DEATH:

County: Harford

City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural - Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Carsins Run
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Matilda V. Schantz

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George F. Schantz

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 6, 1867

8. AGE: Years	Months	Days	If less than one day
80		12	..... hrs. ..... min.

9. Birthplace: Aberdeen, Harford Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Frederick Haya

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Eva C. Buell

MOTHER — 15. Birthplace: Germany

16. Informant: John F. Schantz

Address: Aberdeen, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 21, 1947 (month) (day) (year)

Cemetery or crematory: Bakers

Location: Aberdeen Md.

18. Funeral director: Henry Tarring & Sons

Address: Aberdeen, Md.

19. July 21, 1947 (Date rec'd by registrar) Nellie H. Riley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 18th 1947, at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1947, to July 18, 1947

and that I last saw him alive on July 18, 1947

Immediate cause of death	DURATION
Lobar pneumonia	3 days
Due to: Prolapsus uteri;	
secondary anemia.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Thos. P. Thomas M. D. or other

Address: Aberdeen, Md. Date signed: July 21, 1947.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
JUL

161a Birth & Death 06095

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF ~~STILLBIRTH~~

Reg. Dist. No. 185

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Harford

City or town Perre de Grace
(If outside city or town limits, write RURAL and give nearest town)

Street address, hospital, or institution:
Harford Memorial Hospital

Length of mother's stay in County
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland

County Harford

City or town Aberdeen
(If outside city or town limits, write RURAL and give nearest town)

Street No. 33 Lake St
(If RURAL give LOCATION)

3. Name of child Garry Dee Sheppard

4. Date of birth July 7 1947 Hour 9:53 P.M.

5. Sex M 6. Twin or triplet

7. No. of weeks pregnancy 9 months

FATHER OF CHILD

8. Full name Jack V. Sheppard

9. Color W 10. Age at time of this birth 29 yrs.

11. Usual occupation Mail carrier

MOTHER OF CHILD

12. Full maiden name Eleanore Louise Mehring

13. Color W 14. Age at time of this birth 26 yrs.

15. Usual occupation Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 1

(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None

19. Labor: (a) Complications of None

(b) Induced? Yes

20. (a) Was there an operation for delivery? Yes (Yes or No)

(b) State all operations, if any Outlet forceps.

(c) Did child die before operation? No

During operation? Yes

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Anoxia - Respiratory depression

(b) Maternal causes none

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature John F. Noguera, M.D.
(Specify if M. D., midwife, or other)

Address Harford Mem. Hospital

23. (a) Burial (b) Date thereof July 9 - 1947
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Grove

24. (a) Funeral director Berry Tanning Sons

(b) Address Aberdeen md.

25. (a) July 8-47 (b) A. L. Lewis M.D.
(Date rec'd by registrar) (Registrar)

26. (To be filed out if no physician was present at delivery.) The above certificate has been examined by me.

A. L. Lewis M.D. Health Officer, per

* See Instruction C on stub.

Lived four months

V. S. A10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

06096

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford
City or town: Fallston (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 hours
Hospital, institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution? 12 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Van Bibber Rd - Edgewood, Md (If outside city or town limits, write RURAL and give nearest town)
Street No.: Edgewood Md (If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME Wilmer D. Shepperd WILMER DANIEL SHEPPERD
3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widower

6.(b) Name of husband or wife: Alice Mary Watson
6.(c) If alive, give age: ////// years
7. Birth date of deceased (mo., day, yr.): October 30, 1877

8. AGE: Years	Months	Days	If less than one day
69	8	23	..... hrs. ..... min.

9. Birthplace: Monkton, Balto. Co., Maryland (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: U.S. Mail Carrier
FATHER 12. Name: James M. Shepperd
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary M. Nolan
MOTHER 15. Birthplace: Maryland
16. Informant: Family Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 26, 1947 (month) (day) (year)
Cemetery or crematory: New Cathedral Cemetery
Location: Baltimore, Maryland
18. Funeral director: John Burns' Sons
Address: Towson, Maryland
19. July 26 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 24th 1947 at 2:20 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 23 1947 to July 24th 1947 and that I last saw h... alive on July 24th 1947

	DURATION
Immediate cause of death: Intestinal obstruction	
Due to: Adhesions splenic flexure of colon	
Due to:	
Other conditions: Congestive heart failure contributing cause COD.	

(Include pregnancy within 3 months of death)
Major findings of operations: Intestinal obstruction
Date of op. 7.23.47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F Noguera M.D. M. D. or other
Address: Harford Memorial Hosp Date signed: 7/24/47

VS A16 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

060983
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Nicholas Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Grace Wilcox
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Aug 10 1877

8. AGE:

Years	Months	Days	If less than one day
69			hrs. min.

9. Birthplace: Jarrettsville Harford Co Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired

FATHER
12. Name: Nicholas Smith
13. Birthplace: Rocks Harford Co Md

MOTHER
14. Maiden name: Cassandra Heck
15. Birthplace: Chestnut Hill Harford Co Md

16. Informant: Mrs Grace W. Smith
Address: Forest Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 6-47 (month) (day) (year)
Cemetery or crematory: Christ Church, Rocks Springs
Location: Forest Hill Md

18. Funeral director: Martin E Kurtz
Address: Jarrettsville Md.

19. July 6 1947 (Date rec'd by registrar) Thomas R Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1947, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: J. W. Lammey M.D
Deputy Medical Examiner M.D. or other
Address: Aberdeen, Md Date signed 7/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

516

06098

CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Rural — Street, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Rural — Street.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Emory Church.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: John Henry Stewart

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) (Maiden Name) Name of husband or wife: Sarah Elizabeth Iley

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 16, 1874

8. AGE: Years	Months	Days	If less than one day
73	3	22	— hrs. — min.

9. Birthplace: Street, Harford, Md. (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: Farming

FATHER — 12. Name: Henry Clay Stewart

FATHER — 13. Birthplace: Harford Co. Md.

MOTHER — 14. Maiden name: Mary Ann Baldwin

MOTHER — 15. Birthplace: Harford Co. Md.

16. Informant: Mrs. John H. Stewart

Address: Street, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 10-1947 (month) (day) (year)

Cemetery or crematory: Highland Cemetery

Location: Street, Md.

18. Funeral director: Hubert P. Harkins

Address: Delta, Pa.

19. July 9 1947 (Date received by registrar) M. O. Kirk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1947, at 1:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1, 1946, to July 7, 1947 and that I last saw him alive on July 7, 1947

Immediate cause of death	DURATION
Carcinoma of Prostate Gland.	1 yr.
Due to:	
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Charles A. Noff M.D. M. D. or other

Address: Street, Md. Date signed: 7-8-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93 d

06099

CERTIFICATE OF DEATH

Reg. Diat. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Harford.
City or town: Bel Air - Rural (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 3 yrs.
Hospital, institution, or street address where death occurred: County House
How long in hospital or institution? 3 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen, Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. Bush Chapel Road (If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: George W. Strong

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Single
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 25, 1870

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	8			

9. Birthplace: Abingdon Harford Co. Md. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Thomas W. Strong
13. Birthplace: Perryman, Md.

MOTHER
14. Maiden name: Tabitha Gilbert
15. Birthplace: Harford Co. Md.

16. Informant: Mrs. A. Elizabeth Strong
Address: Aberdeen, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 30, 1947 (month), (day), (year)
Cemetery or crematory: Wesleyan Chapel
Location: Near Aberdeen
18. Funeral director: Henry Taxing & Sons
Address: Aberdeen, Md.

19. 7/28 1947 Priscilla Linwood
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27, 1947, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946 to July 27 1947 and that I last saw him alive on July 24 1947

Immediate cause of death: Chr. Myocardial Disease 4yrs. — DURATION

Due to: ____

Due to: ____

Other conditions: Gen. arteriosclerosis ? (Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work?

23. SIGNATURE: Welland R. Hudson, M. D. or other
Address: Forest Hill Md. Date signed: 7/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d 06100

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:
County Harford Co. Md.
City or town Forest Hill Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Forest Hill Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2831 Guilford Ave Balto.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Clarence H. Treadwell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, ~~married~~, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or ~~wife~~ Elizabeth

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13. 1889.

8. AGE: Years 58. Months Days If less than one day ..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Lasttracker

11. Industry or business

FATHER 12. Name Clarence E. Treadwell
FATHER 13. Birthplace Harford Co Md.

MOTHER 14. Maiden name Cordelia Boyd
MOTHER 15. Birthplace Harford Co Md

18. Informant Bessie B. McMahon
Address Glenn Spring Ave

17. Burial, Cremation, or Removal. Which? Burial Date thereof July 11 1947 (month) (day) (year)
Cemetery or crematory Center Lee
Location Harford Co Md.

18. Funeral director John C Mason
Address 3000 E Baltimore St

19. July 10 1947 (Date rec'd by Registrar) A. W. Redmond Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9th 1947 at 1:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1947, to July 8, 1947
and that I last saw h.. alive on July 8 1947

Immediate cause of death	DURATION
Congestive Heart Failure	1 year
Due to Arteriosclerotic Cardio-Vascular Disease	6 years
Due to	
Other conditions Obesity	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robt A. Barthel M.D.
M. D. or other
Address Forest Hill, Md. Date signed 7/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46b

06101

CERTIFICATE OF DEATH

Reg. Diat. No. 185

1. PLACE OF DEATH:
County Harford.
City or town Havre de Grace.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days.
Hospital, Institution, or street address where death occurred:
Harford mem. Hospital
How long in hospital or institution? 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford.
City or town HAVRE DE GRACE
(If outside city or town limits, write RURAL and give nearest town)
Street No. 712 Ontario St.
(If rural, give LOCATION)
2.(a) If veteran, name war World War #1

3.(a) FULL NAME Mr. William Waring

3.(b) Social Security Number 218-07-2374

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M.

6.(b) Name of husband or wife Una V. Grafton
6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 1st 1895

8. AGE: Years	Months	Days	If less than one day
52	1	1	..... hrs. ..... min.

9. Birthplace Hoylake, England.
(Town, county, and state)
10. Usual occupation Shipfitter,
11. Industry or business Iron worker.

FATHER
12. Name William Waring
13. Birthplace England

MOTHER
14. Maiden name Sophie Jones
15. Birthplace England.

16. Informant Mrs. William Waring
Address 712 Ontario St. Havre de Grace

17. Burial Date thereof July 5 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Deer Creek
Location Churchmount Hill, Md.

18. Funeral director Henry Tarring & Son
Address Aberdeen, Md.

19. July 3 1947 A. L. Lewis M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2nd 1947 at 9.05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29th 1947 to July 2nd 1947
and that I last saw h.. alive on July 2nd 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	
Due to	
Due to	
Other conditions Involving pancreas + duodenum. Also metastases to peritoneum	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John F. Noguera MD
M. D. or other
Address Harford Mem. Hosp. Date signed 7/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

06102

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County HARFORD
City or town RURAL - JOPPA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 YEARS
Hospital, Institution, or street address where death occurred: RURAL ROUTE 1, JOPPA.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County HARFORD.
City or town RURAL - JOPPA.
(If outside city or town limits, write RURAL and give nearest town)
Street No. NEAR STOCKTON
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ISRAC VERGIL WOLFE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M.

6.(b) Name of ~~husband or~~ wife ANNA MAE WOLFE
6.(c) If alive, give age 41 years
7. Birth date of deceased (mo., day, yr.) DEC. 13, 1901

8. AGE: Years	Months	Days	If less than one day
46	7	0	...hrs. ...min.

9. Birthplace MARION, VIRGINIA. (Town, county, and state)
10. Usual occupation GOV'T EMPLOYEE
11. Industry or business U.S. GOVERNMENT.
FATHER 12. Name JAMES R. WOLFE
13. Birthplace VIRGINIA
MOTHER 14. Maiden name NORA ~~WOLFE~~ PARRISH
15. Birthplace VIRGINIA
16. Informant BETTY WOLFE
Address RURAL - JOPPA.
17. Burial ~~Cremation~~ ~~Removal~~ Which? Date thereof July 16th 1947 (month) (day) (year)
Cemetery or crematory Bel Air Burial Park
Location Bel air - md
18. Funeral director W.T. archer
Address Benson md
19. 7/15 1947 (Date rec'd by registrar) Priscilla Fowood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 13 1947 at 7:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 JULY 1947 to 13 JULY 1947 and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death ACUTE MYOCARDIAL FAILURE	2 HOURS
Due to ACUTE CORONARY OCCLUSION	2 HOURS
Due to MYOCARDIAL DISEASE (FIRST NOTED 3 DAYS AGO)	3 DAYS
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Harvey L. Tidwell M.D.
M. D., or other
Address Bel Air, Md. Date signed July 13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13|a

CERTIFICATE OF DEATH

06103

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Harford
City or town: Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred: Harford Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Harford
City or town: Belcamp, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mr. Joseph A. Zukowski

3.(b) Social Security Number 213-16-2133

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Molly J. Zukowski
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Mar. 14, 1883

8. AGE: Years: 64 | Months: 4 | Days: 1 | If less than one day: ...hrs. ...min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER 12. Name: Hilary Zukowski
13. Birthplace: Poland

MOTHER 14. Maiden name: Agnes Zukowski
15. Birthplace: Poland

16. Informant: Mrs. Molly J. Zukowski
Address: Bata Ave. Ext, Belcamp Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: July 18, 1947 (month) (day) (year)
Cemetery or crematory: Cokesbury
Location: Abingdon Md

18. Funeral director: Howard E. McComas
Address: Abingdon, Md.

19. July 18 1947 (Date rec'd by registrar) A. L. Lewis M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1947 at 1:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11 1947 to July 15 1947 and that I last saw h... alive on July 15 1947

Immediate cause of death	DURATION
Uremia - Chronic nephritis - Hypertensive cardiovascular disease	
Due to	
Due to	
Other conditions: Benign prostatic hypertrophy. Right inguinal hernia.	

(Exclude pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Noguera M.D. M. D. or other
Address: Harford Mem. Hosp. Date signed: 7/15/47